

Garrigues (H. J.)

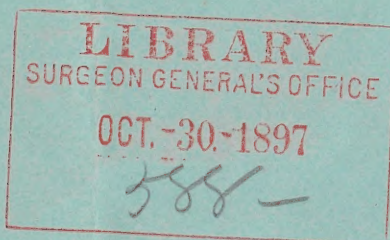
al

SECONDARY OPERATIONS

BY
HENRY J. GARRIGUES, M. D.
NEW YORK.

Reprint from June number, Vol. X,
ANNALS OF GYNECOLOGY AND PEDIATRY
Boston. 1897.

presented by the author



SECONDARY OPERATIONS.

HENRY J. GARRIGUES, M. D.

PATIENTS have sometimes an almost superstitious belief in the efficacy of operative procedures. While they are apt to exaggerate the danger to which they expose themselves by undergoing an operation, and, therefore, are not easily persuaded to have it performed, yet, if they once make up their minds to submit to the knife, they expect that to be the end of all treatment called for in their case. I recently performed colpoperineorrhaphy and Alexander's operation on a patient, who hoped thereby to be cured of dyspepsia and pulmonary tuberculosis.

Gynecologists themselves may be led to form erroneous opinions of the final results of their work. A patient may be sent from the country to a surgical centre; she is operated on, recovers, goes home, and that is often the last the operator hears of her. It

is the same in hospital and dispensary practice in large cities. In case of post-operative trouble the patient often loses confidence in the surgeon who has operated on her, and applies for help in another institution.

Often the operation should only be a link in a chain of measures adopted for the relief of the patient's sufferings, and it need by no means always be the last link. Thus much time, trouble, pain, and expense may sometimes be avoided by a curetting, packing, and drainage of the uterus instituted at the beginning of the treatment, but to be followed by other remedial procedures.

In certain conditions, such as in cases of carcinoma of the womb or breast, the possibility and even the probability of a relapse are so great that the patient should be expressly told to report every few months in order to be reexamined.

LIBRARY
SURGEON GENERAL'S OFFICE

OCT.-30-1897

588-

Sometimes all the additional treatment called for is a mere trifle, and still by delay in seeking advice, the patient may be reduced to a condition of serious suffering and illness as in the following case:

CASE I.—Mrs. S. *æt.* 51. On May 15, 1895, I performed vaginal hysterectomy and double salpingo-oöphorectomy on her for uterine fibroids and chronic oöphoritis. Five weeks later she left St. Mark's Hospital seemingly well, and I did not hear from her for a whole year, when she came to my office in such a condition of weakness that she had to be accompanied to and from my office, and supported while crossing the floor. She complained of frequent attacks of vomiting and diarrhoea, pain in the hypogastric region extending to the sacral region and a constant vaginal discharge. Upon examination I found a small granulating surface at the vault of the vagina, where the opening had been made for the removal of the internal genitals. There was also a tender swelling in both sides of the fornix corresponding to the stumps of the broad ligaments.

The granuloma was healed in a few days by curetting and application of nitrate of silver in substance, when

all discharge ceased. The swelling around the stumps required a longer treatment by electrolysis, under which her dyspeptic troubles disappeared, her strength returned and her pains were reduced to an occasional backache.

In other cases more serious, even capital secondary operations may be required. A frequent cause of a continuation of suffering is more or less extensive adhesions formed in consequence of the primary operation as in the three following cases.

CASE II.—Miss B., aged about 25 years, is one of those patients who wander about from dispensary to dispensary and from hospital to hospital. She was referred to me by Dr. F. C. Valentine, who had been treating her for some bladder trouble.

She had undergone no less than seven laparotomies before I saw her. According to her statement, both ovaries, the appendix vermiformis, and part of the intestine had been removed at various occasions. She complained of intense pain all over the abdomen.

In performing the eighth laparotomy I removed the whole cicatrix, six inches long and four wide, which had resulted from five of the preceding operations, leaving only two scars

on the right side at some distance from the median line, and probably resulting from her scolecectomes and intestinal resection. I found extensive adhesions between the transverse colon and the anterior abdominal wall, which were either torn or cut between two ligatures. This operation freed her from all pain in the abdomen. When she consulted me some time later, it was for inability to urinate, a trouble seemingly due to hysterical paralysis of the detrusor muscle of the bladder. I began to treat her with the faradic current, but soon lost sight of her, whether on account of her being restored to health or on account of her dislike of the treatment, I do not know.

CASE III.—Mrs. L. B., æt. 22, who since the birth of her child, 5 years before, had been suffering from constant backache. Two years before I saw her, she had had both appendages removed. Of late she had complained of much pain in the left lumbar region, and often suffered from headache and dizziness. On July 18, 1896, I removed her uterus from the vagina by Péan's method and then performed laparotomy, making the incision parallel to the old scar, a fingerbreadth to the left of it. Nevertheless I found it very difficult

to work in the hard, thickened tissue. The peritoneum looked like a muscular layer, and was a quarter of an inch thick. Numerous adhesions were found between the omentum and the anterior abdominal wall, which were partly torn, partly tied with a single or double ligature, and cut. An extensive adhesion between the descending colon and the anterior abdominal wall was treated in the same manner. A large portion of the omentum extended down into the left side of the pelvis and was adherent there. This was severed between two ligatures. The patient left the hospital entirely free from pain at the end of three weeks.

CASE IV.—Miss M. K., æt. 26, had been operated on twice before I saw her. After the first operation, consisting in double abdominal salpingo-oöphorectomy she had had severe pain in the right iliac region, which had ceased after the second operation, the nature of which she did not know, but which doubtless had been severance of adhesions. When she consulted me, she had a similar pain on the left side and much backache. In this case I performed, on April 16, 1896, first, laparotomy and then vaginal hysterectomy. The patient being very

stout, it was necessary to make an incision up to the level of the umbilicus. As in the preceding case, it was made a fingerbreadth to the left of the median line, the site of the old scar. The omentum was found extensively adherent on both sides, which adhesions were cut between ligatures; and furthermore there was a roof-like adhesion extending from the sigmoid flexure to the bladder, which could be torn without causing any hemorrhage. The uterus was very small, as it always is after oöphorectomy, the sound entering only two inches. On account of this and the great thickness of the abdominal wall which made it difficult to throw light into the depth of the pelvic cavity, I thought it would be easier to remove the uterus from the vagina, which I did, but the patient being not only a nullipara, but a virgin, the very small dimensions of the vagina made this difficult too. The patient was entirely relieved of her pain, however, and it has never returned, as she told me, when I recently met her, nearly a year after.

In the following two cases I had myself performed salpingo-oöphorectomy, and the complaints continuing I added vaginal hysterectomy.

CASE V.—Mrs. C. C. was referred

to me by Dr. F. M. Bauer. On June 9, 1891, I removed both tubes and ovaries, the latter being the seat of small-cystic degeneration. She had less pain in the abdomen after the operation, but menstruation not only continued, but often was profuse and painful. She was for several months treated with strong galvanic currents according to Apostoli's method and later with the high-tension faradic current. Menstruation ceased three years after the removal of the appendages, but she always had backache and pain in both legs, and consented finally to have the uterus removed, which I did on September 25, 1895, more than four years after the first operation. It was found in an atrophic condition, like that in the preceding case, and imbedded in adhesions, which made the operation somewhat difficult. It was, however, successfully removed by Péan's method. This second operation gave additional relief, but did not cure her. When I saw her again in December of the same year, she still complained of backache and pains in the legs. I found rather considerable swelling around both stumps of the broad ligaments and at the base of the bladder, which improved much under the use of the

galvanic current, and I suppose she has finally recovered.

CASE VI.—Mrs. H., æt. 28 years, had been suffering since the birth of a child seven years before. Palliative treatment having proved ineffectual, I removed both appendages on October 17, 1894. There were no adhesions, and the organs were easily removed through an opening just large enough to admit two fingers. Both ovaries were much enlarged and full of cysts, many of them filled with blood, and the right ovary contained two gyromas. She made a good recovery, but the pain continued unabated. On January 21, 1895, I therefore removed the uterus, using Pratt's method. There were no adhesions, except at the cornua, where the appendages had been tied and cut; but although only three months had elapsed since the removal of the ovaries, the uterus was found atrophic as in the other cases.

While this patient was still confined to her bed, she developed pain in the left side of the abdomen, and on examination it was found that the corresponding kidney had become dislodged, and had sunk down to the level of the crest of the ilium. This is the only case of this kind I have

seen after hysterectomy, but I should not wonder if others were reported. In removing a uterus, especially if it is large, we leave a vacant space which has to be filled with some parts of the contents of the abdomen. As a rule it will be the movable coils of the small intestine that fill out the empty space left between the bladder and the rectum, but it does not seem unlikely that this may occasionally give rise to the disease known as enteroptosis, or Glénard's disease, and especially to floating kidney, a disease which is found much more frequently after childbirth than in nulliparæ, which fact leads us to suppose that the great diminution in size of the womb during labor and involution has something to do with it.

I proposed to perform nephorrhaphy on her, but being unable to obtain a bed for her right away, the operation was performed by another.

Finally, I may briefly refer to a case I have described elsewhere* *in extenso*.

CASE VII.—Mrs. G. V. D., æt. 29. On June 27, 1894, I performed symphysiotomy on her on account of a soft pelvic tumor which prevented the birth of the child, and I delivered

* *Medical Record* vol. xlv. p. 577, Nov. 10, 1894, and vol. xlvii. p. 234, Feb. 23, 1895.

her of one weighing ten and three-quarter pounds. Although there was no mobility in the symphysis pubis, she had a waddling gait, when she got up after the operation, and pain in all the three joints of the pelvis. On December 15, of the same year, I removed both appendages and the uterus from the vagina by the clamp method. One of the ovaries was in a state of small cystic degeneration and the other was changed into a dermoid cyst. She made a good recovery, and her gait became entirely normal. I have seen her two years later, when she was still in excellent health.

Can we do anything to avoid secondary operations, and ought it always to be done?

Since extensive adhesions, as we have seen in some of the above cases, give rise to great and protracted suffering, and necessitate delicate and somewhat dangerous operations, I think we should do what we can to avoid them. Raw surfaces may be covered with peritoneum, but the very sutures we use for this purpose act as an irritant and are covered with newly-formed tissue, very apt to adhere to some neighboring surface. It is also useful to cover such raw surfaces with iodoform or aristol, which

with exuding lymph form a layer that to some extent prevents adhesion. But above all I believe the intestine should be treated with the utmost care. In order to get a view of the pelvic cavity I have seen the intestine covered with coarse towels and pushed up into the upper part of the abdominal cavity. In our just apprehension of infection we are apt to forget that violent mechanical handling, by scraping off the fine endothelium which covers the intestine, and prevents it from adhering to other surfaces, may become injurious in itself, independently of any infectious action. Only the very finest gauze pads or the very softest of sponges should be used in the peritoneal cavity, and they should be used as cautiously as possible. As to unavoidable adhesions, they are in some degree overcome and made innocuous by moving the bowels as soon as the patient has recovered sufficiently to stand it—as a rule forty-eight hours after the operation.

It has become the fashion of late to remove the uterus together with the appendages, and the only point of diversity of opinion seems to be whether it should be done through the abdominal wall or the vaginal roof. In the writer's opinion it

would in many cases be better only to curette the uterus and leave it, even when both appendages are removed. Experience during the twenty years in which Tait's operation was almost universally practiced has shown that with exuding lymph forms a layer were delivered of their sufferings, and restored to good and often robust health. On the other hand the removal of the uterus entails a danger of its own. It is evident that the removal of this organ, even when done rapidly and without loss of blood, causes a much greater shock to the system than the removal of the appendages. If we leave the uterus, the operation is much safer; the uterus undergoes so great an atrophy, that within a few months it shrinks to half its original volume. In most cases it gives no trouble, and is even mechanically useful by filling part of the pelvic cavity and thereby preventing displacements of the organs

enclosed in the upper part of the abdominal cavity. If in exceptional cases the patient is not cured by the salpingo-oöphorectomy; hysterectomy may follow later, when it is both easier and safer. In the meantime the organism has gradually accustomed itself to do without the uterus, and there is little or no shock.

For the swelling often forming around the stumps left by the removal of the appendages or the uterus, I have found the electrolytic effect of a strong galvanic current applied to the vaginal roof and the abdominal wall very useful, both in regard to absorption and relief from pain.

Granulomas found in the vagina, at the place where hysterectomy has been performed or where pelvic abscesses have been opened, yield rapidly to curetting, application of lunar caustic, and cleanliness.

New York City.

Annals
of
GYNECOLOGY AND PEDIATRY.

A monthly journal of Gynecology, Obstetrics, Abdominal Surgery and the Diseases of Children; devoted to reliable pathology, clean surgery, accurate diagnosis, and sensible therapeutics.

Subscription Price—\$3.00 per year.

168 NEWBURY ST., BOSTON, MASS.